PATIENT INFORMATION

Name: _____ **Today's Date:** _____
Address: _____
_____

Telephone #: ( )_____ **Cell Phone#:** ( )_____

Date of Birth: _____ **SS#:** _____

Referred By: _____

Address: _____
_____

Emergency Contact: _____ **Phone:** ( )_____

Occupation: _____

General Functioning Complaints? (sleeplessness, low energy, etc.): _____
_____
_____
_____

Reason for seeking counseling? _____
_____
_____
_____

What do you want to accomplish in counseling? : _____
_____
_____
_____

Have you ever seen a counselor for mental health/emotional reasons?_____ if so, who/what facility:

Name of Therapist: _____
Address: _____
_____
Reason for leaving:_____
_____
Approximate date of last appointment?_____

HEALTH INFORMATION

List any significant crises, losses or stressors?

_____

Do you have any medical conditions?

_____

Are you on any medications currently? _____if so, please list.

_____

_____

Primary Physician's Name: _____ Last Physical _____

Address_____

_____

Have you ever been hospitalized for mental health/emotional reasons?_____ if so, who/what facility or hospital:

Name of Therapist/Hospital:_____

What was the outcome?_____

_____

Date of Hospitalization:_____

Have you had a history of any of the following?

	Yes	No		Yes	No
Addictions			Heart Disease		
Allergies			Hypertension		
Anemia			Gynecological Problems		
Asthma			Learning Disabilities		
Cancer			Physical Handicap		
Depression			Seizures/ Neurological Problem		
Diabetes			Sleep Problem		
Dizziness			Substance Abuse		
Gastro Intestinal Problems			Thyroid Problem		
Headaches			Other		

If you have answered yes to any of the above questions, please describe: _____

_____

_____

Specify (include Family history of above) _____

Medications: Prescribed and/or over the counter – _____

Present: _____

Past: _____

Is there a family history of emotional problems? _____

INSURED/RESPONSIBLE PARTY INFORMATION

Please complete this section regardless of insurance coverage.

Full Name of Insured: _____ Relationship: _____ Occupation: _____

Home Address: _____ Phone: ( ) _____

Employer and Address: _____ Phone: ( ) _____

Insured's SS#: _____

Full Name of Spouse: _____ SS#: _____

Spouse's Employer: _____ Phone: ( ) _____

Insured Primary Ins.: _____ I.D. # _____ Group# _____

Secondary Ins. Co. __ No ___Yes; Company: _____

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for service provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

Name : _____
Signature: _____ **Date:** _____

Expectations from Therapy: Client's Responsibilities

People utilize therapy to help change what are often significant aspects of themselves (attitudes, behaviors, emotions, etc), their relationships or other circumstances in life in order to lead a more fulfilling life. As a client, you will be expected to take an active role. As a professional, I can assist in effecting change, but cannot guarantee a specific outcome. You will determine the direction and be ultimately responsible for growth. If at any time you are dissatisfied with your therapy, please let me know in order that we can work together toward a solution.

Confidentiality

All information you reveal will be treated strictly confidential according to the attached HIPPA regulations. This means that the information will not be shared with anyone with the following three exceptions (1) when you have given written consent to share the information with a specific person or agency, (2) when it is deemed that you are at risk of hurting yourself or another person and (3) New York State law requires that child abuse in any form be reported to Child Protective Services.

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that in an attempt to protect the privacy of my identifiable health information, Meryl Feldman, LCSW-R has established a Privacy Policy and guidelines within her office. This policy details the use and/or disclosure of information contained in my personal mental health records. In accordance with HIPPA regulations, a copy of this information can be made available to me while in the office with advance notice.

Signature: _____ **Date:** _____

SERVICE AGREEMENT

Please read this form carefully and as thoroughly as possible. Initialing indicates that you understand and agree to the stated terms.

1. **Appointments must be canceled at least 24 hours prior to the appointment or the client will be billed for the session at a rate of $100 regardless of the insurance agreement.**

   Initial_____

2. Out-of-office consultations---hospital visits, home visits, court appearances, or other types of consultations (which require the therapist to leave the office to provide counsel or consultation) can be provided to the client at a fee of $200 per session hour. Travel time to and from will be billed at this same rate. This is an out-of-pocket expense and cannot be billed to your insurance company. **This excludes all school meetings.** Initial_____

3. **I understand that if I'm here with a minor, collateral sessions were both parents present is required at therapists request. Refusal could lead to termination.** Initial_____

4. Therapy sessions consist of a 45-minute "hour". If session last longer than 45 minutes, they will be billed on a pro-rated basis. Clients using their insurance will be billed for an additional day. Initial_____

5. Therapist rate is $125 per session unless otherwise discussed. Initial_____

6. It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance the day and time service is provided. Initial_____

7. **Payment is due when services are received**. Please make checks out to cash. Initial_____

8. If for any reason payment for services is not received within thirty (30) days after the services were rendered, there will be a $25 per month carrying charge. Initial_____

9. There will be a $25 charge on all returned checks. Initial_____

10. In order for therapy to be successful, attendance is important. **I understand that should I miss three (3) consecutive appointments without prior discussion, therapist will terminate treatment.** Initial_____

11. I understand the above policies and agree to these provisions. Initial_____

Signed_____Date:_____

Thank you for your cooperation in completing this form!

Notice of Privacy Practices
HIPAA AWARENESS

This document describes how your mental health information (MHI) as a client of Meryl Feldman, LCSW-R may be used and disclosed:

Commitment to Privacy
I know how important your personal MHI is and am committed to respecting and protecting it. In conducting sessions, I will create notes regarding you and your treatment. I am required by law to maintain the confidentiality of all MHI that identifies you. I am also required by law to provide you with this notice of my legal duties and my privacy practices.

The terms of this notice apply to all records containing your protected MHI that are created or retained by my office. Generally this would include your intake form, office notes, any assessments, homework or personal journals you supply, insurance forms, diagnosis information and appointment receipts. I reserve the right to revise or amend this notice at any time. Any revision or amendment to this notice will be effective for all your past records that I have created or maintained as well as any records that may be created or maintained in the future.

Meryl Feldman, LCSW-R may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

- may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assists, Meryl Feldman, LCSW-R in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

- may mail to my home or other designated location any items that assists, Meryl Feldman, LCSW-R in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and/or Confidential.

- may mail to my home or other designated location any items that assists, Meryl Feldman, LCSW-R in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Meryl Feldman, LCSW-R restrict how she uses or discloses my PHI to carry out TPO. However, Meryl Feldman, LCSW-R is not required to agree to my requested restrictions, but if she does, she is bound by this agreement.

I may revoke my consent in writing except to the extent that Meryl Feldman, LCSW-R has already made disclosures in reliance upon my prior consent.

Please keep this page for your records.